MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Active Behavioral Health, LLC 6300 Samuell Blvd., Suite 112 Dallas, Texas 75228	MDR Tracking No.: M4-04-1596-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Royal Indemnity Company Box 42	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 290905350700

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/09/03	01/09/03	90801	$180.00	$180.00
01/09/03	01/09/03	90825	$120.00	$120.00
01/09/03	01/09/03	90889	$240.00	$240.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement carriers "response shall not address new or additional denial reasons or defenses after filing of an initial request."

PART IV: RESPONDENT'S POSITION SUMMARY

No response found in the case file.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Carrier preauthorized services for the date of service 01/09/03. The carrier did not submit a response or an EOB to Medical Dispute Resolution.

Requestor submitted a signed green card on 09/07/03 indicating that the carrier had received the request for reconsideration. Therefore, this dispute will be reviewed per MFG guidelines. Requestor submitted preauthorization to the carrier and was approved per letter dated 06/06/03. Requestor also submitted documentation that supports the delivery of services in accordance with the MFG.

Therefore, based on this evidence reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $540.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Michael Bucklin	12/13/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____